DEPARTMENT OF HEALTH CARE FINANCING ADMINISTRATION — HUMAN SERVICES

FORM APPROVED OMB NO. 0938-01

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 2

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ ~~97,637~~ 98,148 *
b. FFY 2002 $ 387,364

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, Appendix I, Page 2-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, Appendix I, Page 2-7 (TN 00-008)

10. SUBJECT OF AMENDMENT:
Establish Under 16 Bed ICF/MR rates effective July 1, 2001.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ray Hanley

14. TITLE:
Director

15. DATE SUBMITTED:
4/27/01

16. RETURN TO:
Arkansas Division of Medical Services
P.O. Box 1437, Slot 1103
Little Rock, AR 72203-1437

Attention: Binnie Alberius

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
May 4, 2001

18. DATE APPROVED:
July 3, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operat

RECEIVED MAY 2001

23. REMARKS:
* Per e-mail change per States 5/10/01 request.

FORM HCFA-179 (07-92)

Instructions on Back

B. Intermediate Care Facilities for the Mentally Retarded – Continued

3. Under 16 Beds:

a. Small ICF/MR facilities certified as having 15 beds or fewer will be reimbursed on a prospective uniform class rate system. An inflationary adjustment, determined by the Division to be reasonable and adequate, will be applied to the existing rates and will be implemented by State Plan amendment as warranted by analysis of cost report data. Cost reports will be submitted annually for the preceding calendar year (January 1 – December 31) and will be reviewed prior to establishing new rates. The Division has established the per diem rate of $157.10 effective July 1, 2001. This 3.2% increase in per diem rate is based on the HCFA Market Basket forecast for nursing home index as an inflation factor.

b. Overpayment/Underpayments

Overpayment/underpayments resulting from Section 1-12 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments.

SUPERSEDES: TN - AR-00-08

STATE Arkansas
DATE REC'D 05-04-01
DATE APPV'D 07-03-01
DATE EFF 07-01-01
HCFA 179 AR-01-12

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